PARENT QUESTIONNAIRE
Four Years and Older

Child's Name: _____ **DOB:** _____ **Date:** _____

PERSONAL CHARACTERISTICS
Please indicate how often these behaviors occur in the child by circling the letter which most often describes it.
O = occurs Often S = Seldom N = Never

Impulsive	O	S	N	Over reacts	O	S	N
Nervousness	O	S	N	Tongue sucking	O	S	N
Sleeplessness	O	S	N	Hurting Pets	O	S	N
Nightmares	O	S	N	Setting Fires	O	S	N
Bedwetting	O	S	N	Constipation	O	S	N
Walking in sleep	O	S	N	Face Twitching	O	S	N
Showing Off	O	S	N	Nervous Habits (tics)	O	S	N
Shyness	O	S	N	Fainting	O	S	N
Poor Attn. span	O	S	N	Strong Fears	O	S	N
Refusal to Obey	O	S	N	Strong Hates	O	S	N
Whining	O	S	N	Thumb Sucking	O	S	N
Unusual Food Habits	O	S	N	Temper Tantrums	O	S	N
Poor Attn. Span	O	S	N	React Negatively to smells	O	S	N
Chew on non-food items	O	S	N	Confusion over hand dominance	O	S	N
Resistant to changes	O	S	N	Fighting	O	S	N

Special Likes: _____
_____
Comments: _____
_____

Please list any physicians, therapists, social workers, or other professionals that have worked or are working with your child.

Name/ Agency	Month/Year	Title	Phone	Fax

SOCIAL ADJUSTMENTS
Please explain your answers. Does your child:
1. Find it hard to make friends among his peers?

_____
_____

2. Prefer the company of adults or older children?

_____
_____

3. Prefer to play with younger children?

_____
_____

4. Frequently express feelings of failure?

_____
_____

 Child's Name: _____

PHYSIOLOGICAL DATA

Diseases:	Age	Severity	Change in Speech	Chges in Mvmt / Behavior	
Chicken Pox	_____	_____	_____	_____	_____
Measles	_____	_____	_____	_____	_____
Scarlet Fever	_____	_____	_____	_____	_____
Rheumatic Fever	_____	_____	_____	_____	_____
Pneumonia	_____	_____	_____	_____	_____
Influenza	_____	_____	_____	_____	_____
Asthsma	_____	_____	_____	_____	_____
Hay Fever	_____	_____	_____	_____	_____
Other Respiratory Illness	____	_____	_____	_____	_____
Diptheria	_____	_____	_____	_____	_____
Encephalitis	_____	_____	_____	_____	_____
Mumps	_____	_____	_____	_____	_____
Meningitis	_____	_____	_____	_____	_____
Whooping cough	_____	_____	_____	_____	_____
Allergy	_____	_____	_____	_____	_____
High Fevers (104)	_____	_____	_____	_____	_____
Earaches	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Constipation	_____	_____	_____	_____	_____
Others	_____	_____	_____	_____	_____

Surgeries: _____

_____

Injuries: _____

_____

Injuries or illnesses related to speech problems: _____

_____

Comments: _____

_____

PROPRIOCEPTIVE: Does your child?

1. Walk on toes or did when younger?	O	S	N
2. Have difficulty with motor coordination for small things?	O	S	N
3. Development include going from sitting to standing with little / no crawling?	O	S	N

VESTIBULAR: Does your child?

1. Seem fearful of space (going up & down stairs, riding teeter totter, going through small enclosed area)?	O	S	N
2. Dislike merry go rounds?	O	S	N
3. Get car sick?	O	S	N
4. Dislike being rocked now or as infant?	O	S	N
5. Have poor balance?	O	S	N

 Child's Name: _____

SPEECH HISTORY:

1. a. Age first words spoken: _____
   b. Age 2-3 word combinations spoken: _____
   c. Age first sentences spoken: _____

2. Rate of speech development: Fast _____ Average _____ Slow _____
   Clearness of child's speech before age 6:
   Below Average _____ Average _____ Above Average _____

3. Verbal output:

	More than average	Average	Less than average
a. amount of babbling	_____	_____	_____
b. amount of talking when first began	_____	_____	_____
c. amount of talking at present	_____	_____	_____
d. present rate or speed of talking (fast, slow)	_____	_____	_____

Comments: _____
_____

CURRENT SPEECH:

Can your child:	Yes	No
1. Rhyme three words?	Y	N
2. Identify alphabet letters by end of Kindergarten?	Y	N
Does your child:	Y	N
3. Experience reading problems?	Y	N
4. Have a learning disability?	Y	N

Please comment: _____
_____
_____

VISUAL: Does your child?

1. Make reversals when copying?	O	S	N
2. Appear to be happier in dark / dim light?	O	S	N

TACTILE: Does your child?

1. Avoid playing with "messy" things (finger paint, pastm mud, sand)?	O	S	N
2. Appear to be irritated by cloth of certain textures?	O	S	N
3. Object to being touched / cuddled ?	O	S	N
4. Prefer to touch rather than be touched?	O	S	N
5. Bang his head o purpose in past or now?	O	S	N
6. Pinch, bite, or otherwise hurt himself?	O	S	N
7. Pinch, bite, or otherwise hurt others?	O	S	N
8. Tend to feel pain less than others?	O	S	N
9. Tend to feel pain more than others?	O	S	N
10. Frequently bump or push other children?	O	S	N